L'AGORA' PENITENZIARIA 2019
XX Congresso Nazionale SIMSPe-ONLUS
IL CARCERE È TERRITORIO

PREVENZIONE CARDIOLOGICA PRIMARIA E SECONDARIA NEGLI ISTITUTI PENITENZIARI

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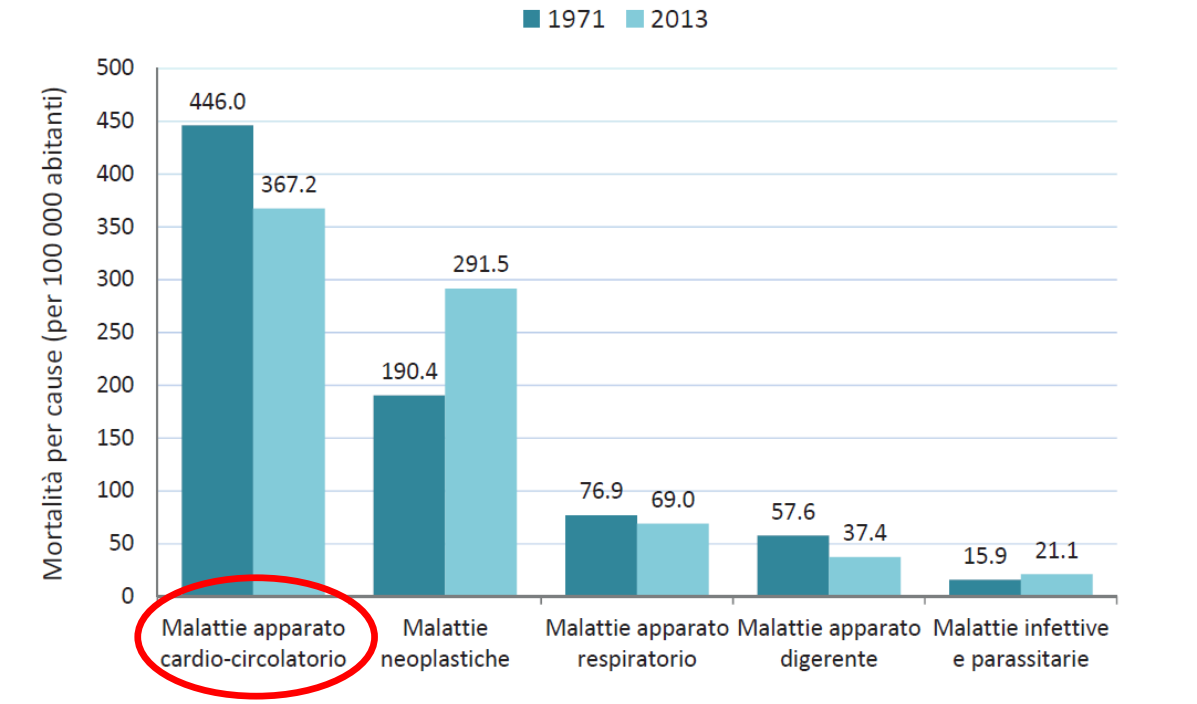
Le malattie CV rappresentano la **prima** causa di morte nel mondo con una stima di circa 17 milioni decessi/anno.

Analogamente ancora oggi in Italia la **prima** causa di decessi e la **prima** causa di ricovero ospedaliero (14.5% di tutti i ricoveri) è rappresentata dalle malattie CV.



Mortalità per cause negli anni 1971 e 2013. Fonte ISTAT.

Documento di consenso e raccomandazioni per la prevenzione cardiovascolare in Italia 2018 ***GIC 2018, 19 (2 suppl)***

I progressi in ambito sanitario hanno permesso di prolungare **l'aspettativa di vita**
→ a 65 anni a.v. = 18 aa negli ♂ / 21 aa nelle ♀**.**

Il prolungamento dell'a.v. **non è** stato accompagnato da una proporzionale **riduzione della morbidità** cioè l'allungamento dell' a.v. non va di pari passo con la durata dell'aspettativa di «vita in salute».

La causa principale è da attribuirsi a un' insufficiente riduzione della prevalenza dei FRCV

I FATTORI DI RISCHIO CARDIOVASCOLARE

- **NON MODIFICABILI**
  - Familiarità (genetica)
  - Età
  - Sesso
- **MODIFICABILI (trattabili)**
  - Ipertensione arteriosa
  - Dislipidemia
  - Diabete
  - Obesità/sovrappeso
  - Fumo
  - Sedentarietà
  - (HIV di per sè ↑RCV + dislipidemia indotta da TARV)

LA PREVENZIONE PRIMARIA E SECONDARIA CARDIOVASCOLARE

- PRIMARIA: **prima** che il paziente abbia un evento cardiovascolare
- SECONDARIA: **dopo** un evento cardiovascolare documentato

Stabilita la forte correlazione tra **FRCV** e progressione della **patologia aterosclerotica** e degli **eventi clinici** correlati, la stima del

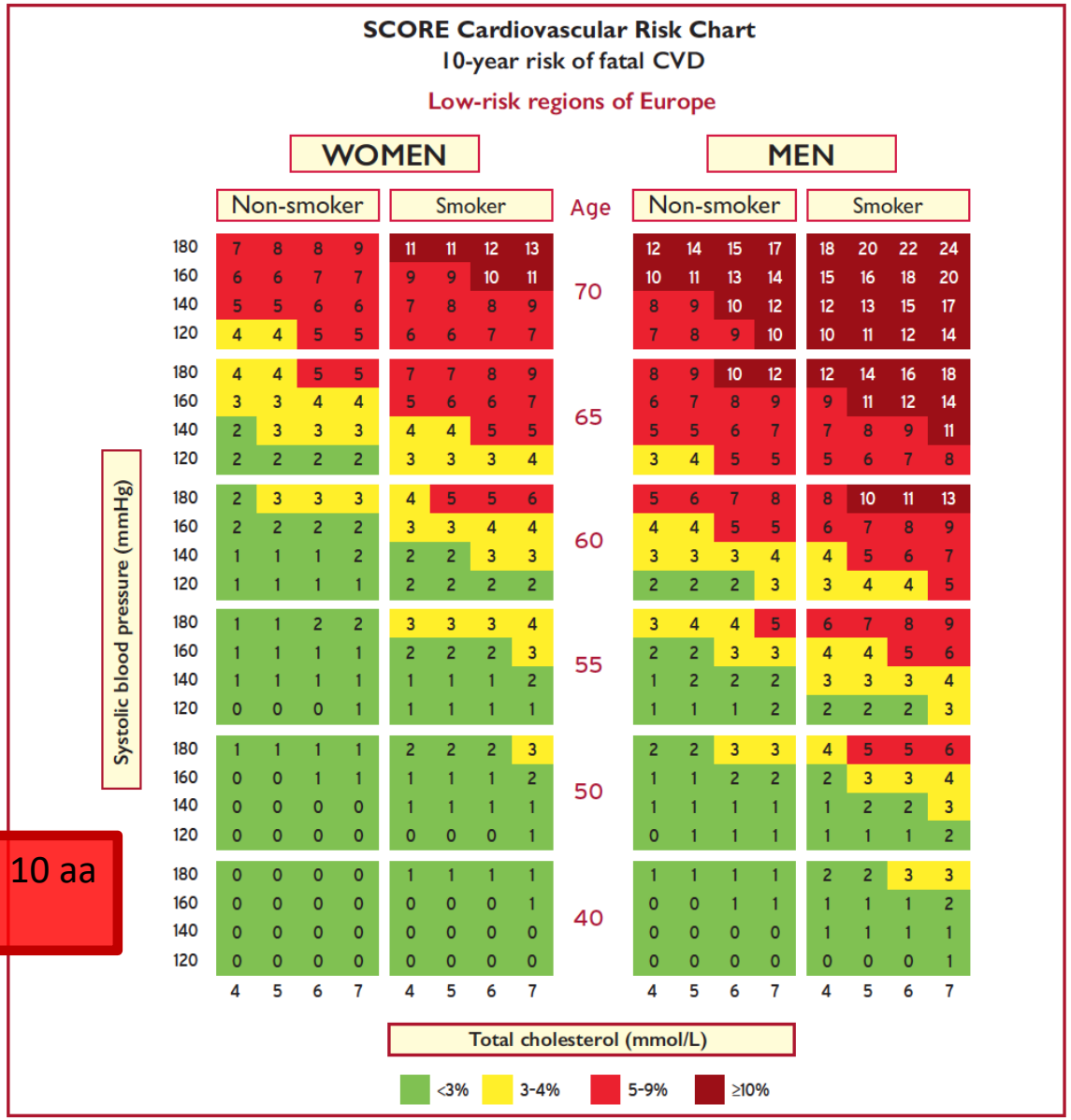
«rischio CV globale»

del singolo paziente è diventato strumento fondamentale per le decisioni clinico/terapeutiche e da qui l'utilizzo delle cosiddette

"CARTE DEL RISCHIO"

(SCORE: Systematic COronary Risk Evaluation)

PUNTEGGIO = % di **morti** per evento CV a 10 aa
PUNTEGGIO X 3 = % di **eventi** CV a 10 aa



ALTO

MOLTO ALTO

I pazienti con:

- **Malattia CV nota**
- **Diabete mellito tipo 1 e 2**
- **Valori molto elevati di FR individuali**

sono automaticamente considerati **pazienti ad ALTO/MOLTO ALTO rischio CV** e pertanto in essi le carte del rischio non si applicano

Cardiovascular risk categories	
Very-high-risk	People with any of the following: Documented ASCVD, either clinical or unequivocal on imaging. Documented ASCVD includes previous ACS (MI or unstable angina), stable angina, coronary revascularization (PCI, CABG, and other arterial revascularization procedures), stroke and TIA, and peripheral arterial disease. Unequivocally documented ASCVD on imaging includes those findings that are known to be predictive of clinical events, such as significant plaque on coronary angiography or CT scan (multivessel coronary disease with two major epicardial arteries having >50% stenosis), or on carotid ultrasound. DM with target organ damage,[a] or at least three major risk factors, or early onset of T1DM of long duration (>20 years). Severe CKD (eGFR <30 mL/min/1.73 m^2). A calculated SCORE ≥10% for 10-year risk of fatal CVD. FH with ASCVD or with another major risk factor.
High-risk	People with: Markedly elevated single risk factors, in particular TC >8 mmol/L (>310 mg/dL), LDL-C >4.9 mmol/L (>190 mg/dL), or BP ≥180/110 mmHg. Patients with FH without other major risk factors. Patients with DM without target organ damage,[a] with DM duration ≥10 years or another additional risk factor. Moderate CKD (eGFR 30–59 mL/min/1.73 m^2). A calculated SCORE ≥5% and <10% for 10-year risk of fatal CVD.
Moderate-risk	Young patients (T1DM <35 years; T2DM <50 years) with DM duration <10 years, without other risk factors. Calculated SCORE ≥1 % and <5% for 10-year risk of fatal CVD.
Low-risk	Calculated SCORE <1% for 10-year risk of fatal CVD.

RISCHIO MOLTO ALTO

Pz con:

- EVENTI CARDIO-CEREBRO-VASCOLARI: infarto miocardico, angina stabile, rivascolarizzazione miocardica o altra rivascolarizzazione arteriosa, ictus o TIA, arteriopatia periferica
- Malattia aterosclerotica significativa (coronarica o TSA) documentata con imaging
- DM con danno d'organo o con ≥ 3FRCV o DM tipo 1 da oltre 20 aa
- Severa IRC con eGFR < 30 ml/min/1.73 mq
- Ipercolesterolemia familiare + 1 altro FRCV
- **SCORE ≥ 10**

RISCHIO ALTO

- Valori molto elevati di FR individuali (es. PA>180/110 mmHg; COL-T > 310 mg/dl; LDL > 190 mg/dl)
- IRC moderata (30< eGFR < 60 ml/min/1,73mq)
- DM senza danno d'organo presente da > 10 aa
- Ipercolesterolemia familiare senza altri FRCV
- **SCORE ≥ 5% e < 10%**

RISCHIO MODERATO

- Giovani (DMt1 < 35 aa – DMt2 < 50aa) con DM da <10 aa senza altri FRCV
- **SCORE ≥ 1% e < 5%**

RISCHIO BASSO: Pz con **SCORE < 1%**

IPERTENSIONE ARTERIOSA

ESC European Society of Cardiology
European Heart Journal (2018) 39, 3021–3104
doi:10.1093/eurheartj/ehy339
ESC/ESH GUIDELINES

2018 ESC/ESH Guidelines for the management of arterial hypertension

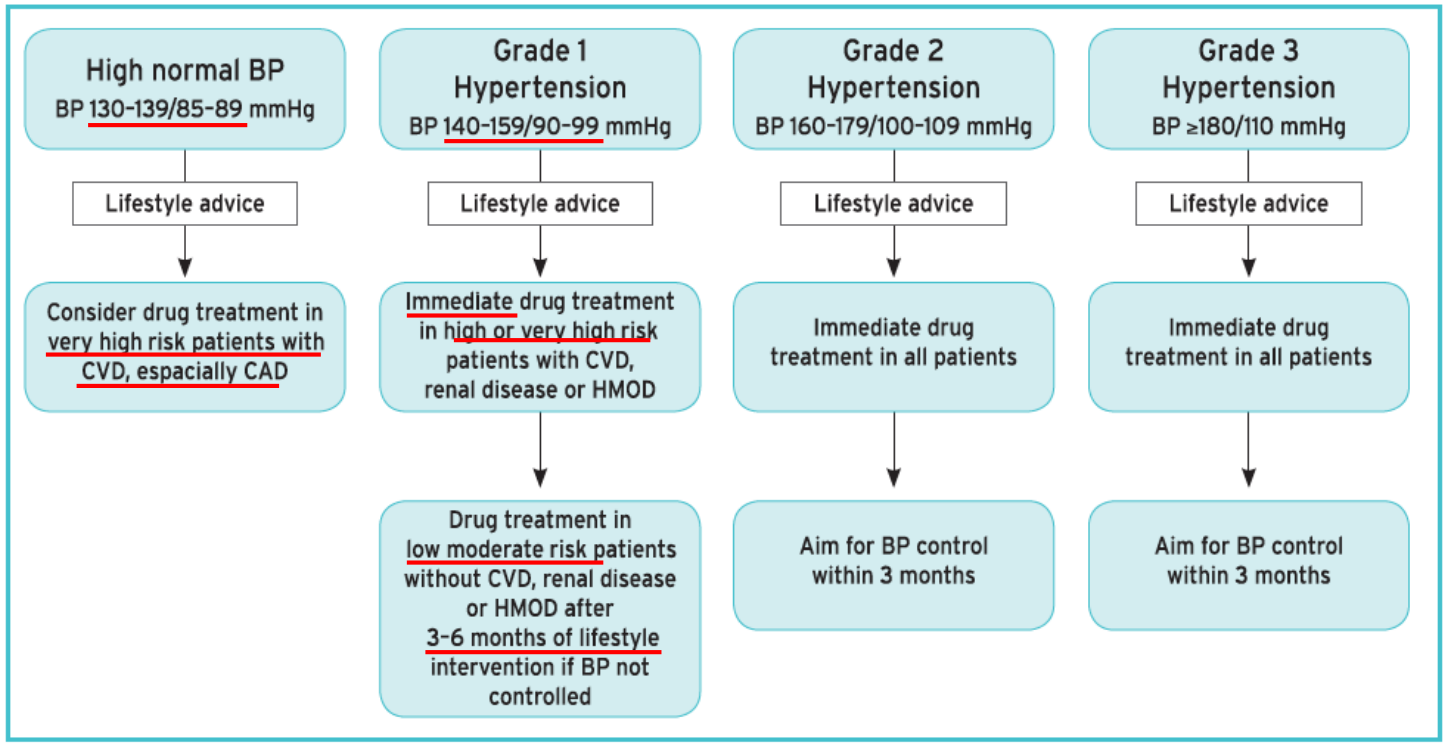


Figure 3 Initiation of blood pressure-lowering treatment (lifestyle changes and medication) at different initial office blood pressure levels. BP = blood pressure; CAD = coronary artery disease; CVD = cardiovascular disease; HMOD = hypertension-mediated organ damage.

- **PRIMO OBIETTIVO PER TUTTI: < 140/90 mmHg**
- SE TOLLERATO: 130/80 mmHg
- < 65 aa 120-129/70-80 mmHg

QUALE TERAPIA?

Drug treatment strategy for hypertension

Recommendations	Class[a]	Level[b]
Among all antihypertensive drugs, ACE inhibitors, ARBs, beta-blockers, CCBs, and diuretics (thiazides and thiazide-like drugs such as chlorthalidone and indapamide) have demonstrated effective reduction of BP and CV events in RCTs, and thus are indicated as the basis of antihypertensive treatment strategies.[2]	I	A
Combination treatment is recommended for most hypertensive patients as initial therapy. Preferred combinations should comprise a RAS blocker (either an ACE inhibitor or an ARB) with a CCB or diuretic. Other combinations of the five major classes can be used.[233,318,327,329,341–345]	I	A
It is recommended that beta-blockers are combined with any of the other major drug classes when there are specific clinical situations, e.g. angina, post-myocardial infarction, heart failure, or heart rate control.[300,341]	I	A
It is recommended to initiate an antihypertensive treatment with a two-drug combination, preferably in an SPC. Exceptions are frail older patients and those at low risk and with grade 1 hypertension (particularly if SBP is <150 mmHg).[342,346,351]	I	B
It is recommended that if BP is not controlled[c] with a two-drug combination, treatment should be increased to a three-drug combination, usually a RAS blocker with a CCB and a thiazide/thiazide-like diuretic, preferably as an SPC.[349,350]	I	A
It is recommended that if BP is not controlled[c] with a three-drug combination, treatment should be increased by the addition of spironolactone or, if not tolerated, other diuretics such as amiloride or higher doses of other diuretics, a beta-blocker, or an alpha-blocker.[310]	I	B
The combination of two RAS blockers is not recommended.[291,298,299]	III	A

ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; BP = blood pressure; CCB = calcium channel blocker; CV = cardiovascular; RAS = renin-angiotensin system; RCT = randomized controlled trial; SBP = systolic blood pressure; SPC = single-pill combination.
[a]Class of recommendation.
[b]Level of evidence.
[c]Adherence should be checked.

TP DI **ASSOCIAZIONE (2 farmaci):** ACE/ARB + CCB o diuretico

BB **solo** se necessario

1 FARMACO solo in pz **anziani fragili** e pz a **basso rischio con IPA 1°**

NO ACE + SARTANO

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DISLIPIDEMIA

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European Heart Journal (2019) 00, 1–78
doi:10.1093/eurheartj/ehz455

2019 ESC/EAS Guidelines for the management of dyslipidaemias: *lipid modification to reduce cardiovascular risk*

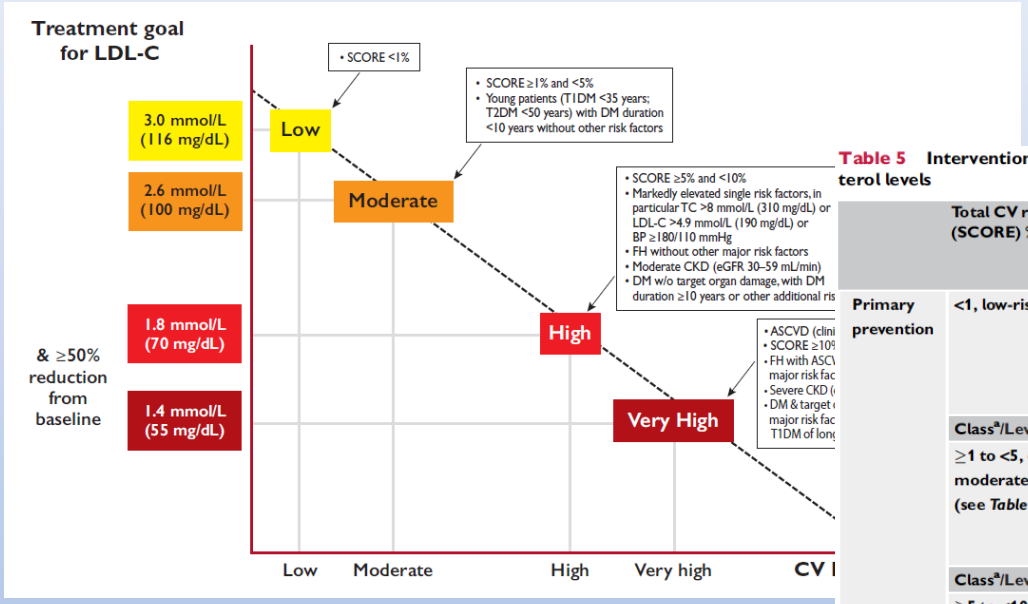

Table 5 Intervention strategies as a function of total cardiovascular risk and untreated low-density lipoprotein cholesterol levels

	Total CV risk (SCORE) %	Untreated LDL-C levels <1.4 mmol/L (55 mg/dL)	1.4 to <1.8 mmol/L (55 to <70 mg/dL)	1.8 to <2.6 mmol/L (70 to <100 mg/dL)	2.6 to <3.0 mmol/L (100 to <116 mg/dL)	3.0 to <4.9 mmol/L (116 to <190 mg/dL)	≥4.9 mmol/L (≥190 mg/dL)
Primary prevention	<1, low-risk	Lifestyle advice	Lifestyle advice	Lifestyle advice	Lifestyle advice	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	I/C	I/C	I/C	I/C	IIa/A	IIa/A
	≥1 to <5, or moderate risk (see *Table 4*)	Lifestyle advice	Lifestyle advice	Lifestyle advice	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	I/C	I/C	IIa/A	IIa/A	IIa/A	IIa/A
	≥5 to <10, or high-risk (see *Table 4*)	Lifestyle advice	Lifestyle advice	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	IIa/A	IIa/A	IIa/A	I/A	I/A	I/A
	≥10, or at very-high risk due to a risk condition (see *Table 4*)	Lifestyle advice	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	IIa/B	IIa/A	I/A	I/A	I/A	I/A
Secondary prevention	Very-high-risk	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	IIa/A	I/A	I/A	I/A	I/A	I/A

QUALE TERAPIA?

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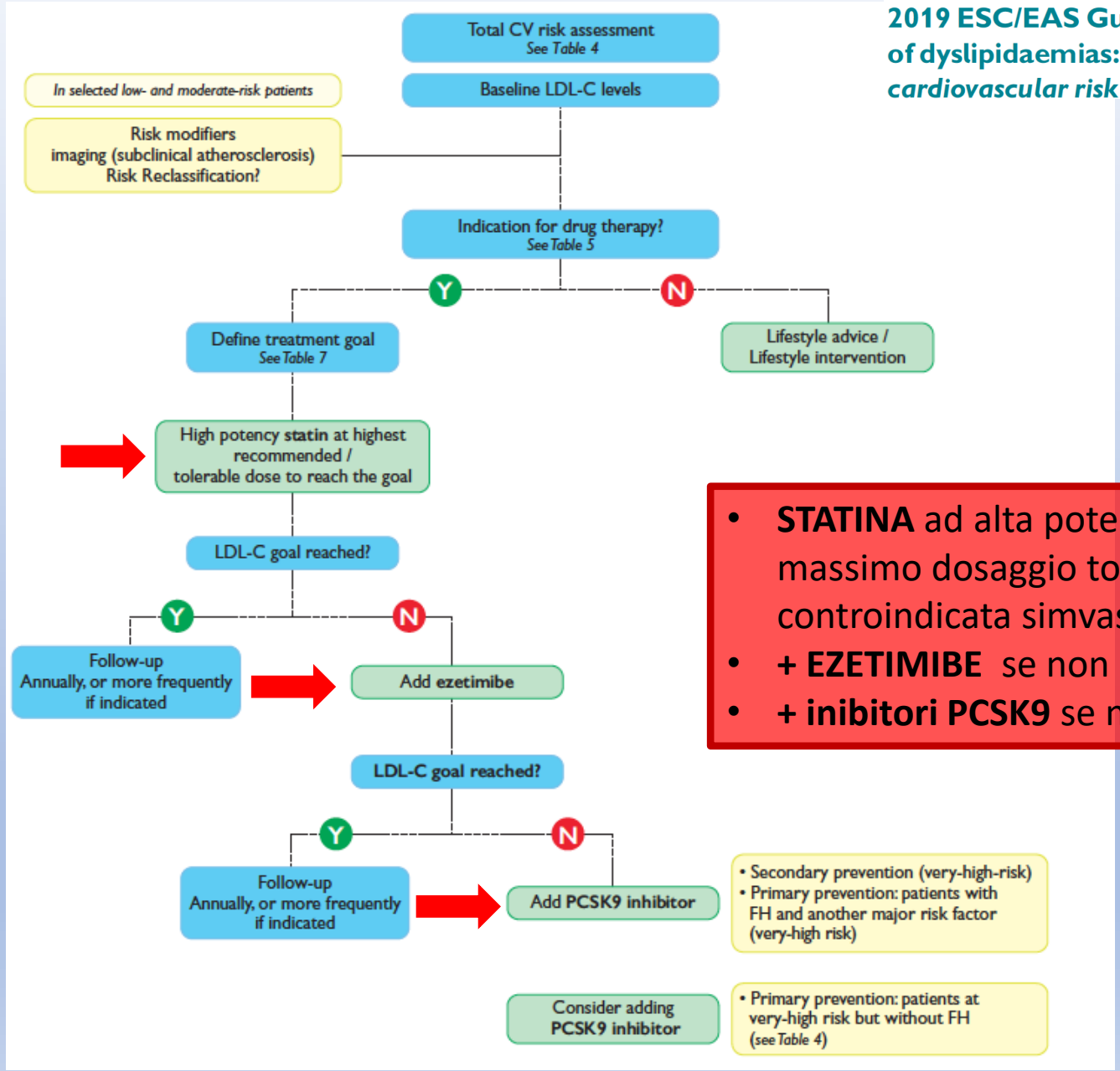


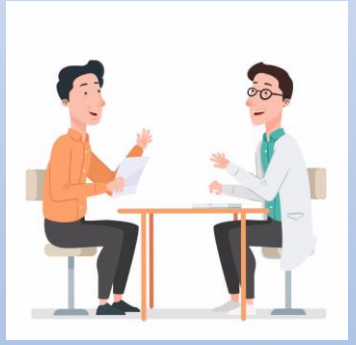
- **STATINA** ad alta potenza (atorva/rosu) al massimo dosaggio tollerato (in HIV controindicata simvastatina)
- **+ EZETIMIBE** se non raggiunto target
- **+ inibitori PCSK9** se non raggiunto target

NELLA PRATICA E PER TUTTI:
COME INQUADRARE IL PAZIENTE E STIMARE IL SUO RISCHIO CV?

1) Anamnesi: prevenzione CV PRIMARIA o SECONDARIA
2) Monitoraggio valori PA → IPA si/no, valori ed eventuale tp adeguata
3) Dosaggio col tot e LDL per capire da dove partiamo e dove dobbiamo arrivare
4) **PUNTEGGIO SCORE**
5) Screening diabete misconosciuto (glicemia, Hb glicata)
6) Screening fumo e counseling
7) Stile di vita, dieta adeguata, calo di peso ed attività fisica regolare

MA SOPRATTUTTO

INFORMARE il paziente su FRCV e OBIETTIVI da raggiungere
perché senza **INFORMAZIONE** non si può fare **PREVENZIONE**

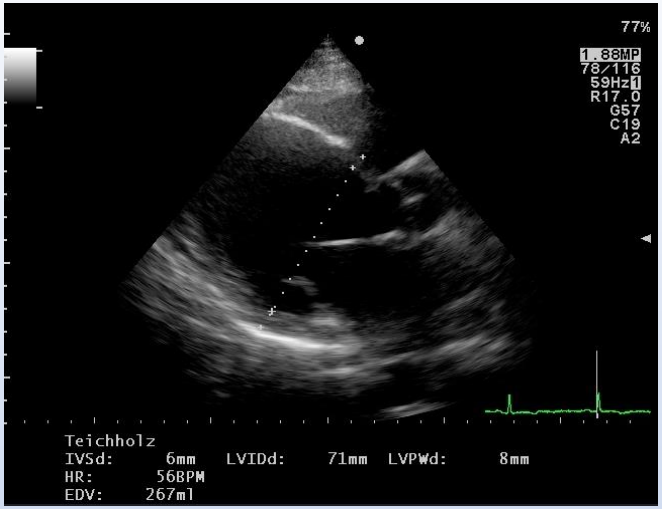


→ DETENUTI spesso con **livello socio-culturale basso e problemi di comprensione della lingua parlata,** anche coloro che hanno già avuto eventi **NON sempre hanno compreso la malattia**

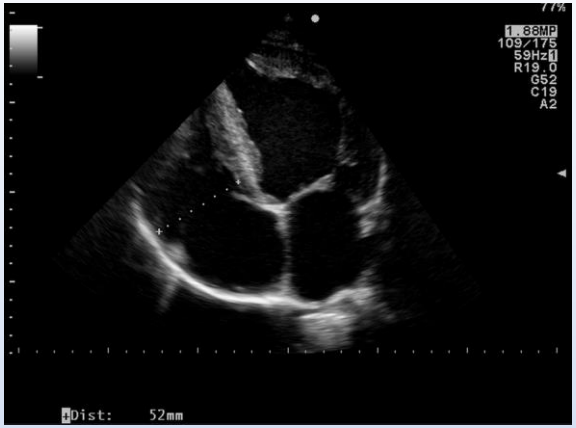
→ la carcerazione può quindi essere un'occasione di riprendere in mano la propria vita anche dal punto di vista sanitario

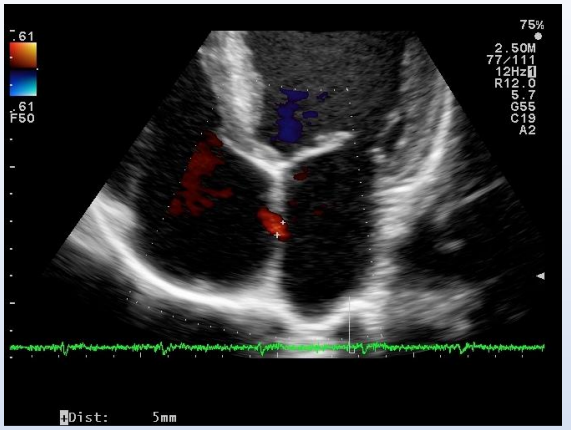
CARDIOLOGIA IN CARCERE NON E' SOLO PREVENZIONE PRIMARIA E SECONDARIA MA ANCHE

PRIMA DIAGNOSI O **PRIMA RIVALUTAZIONE** **(spesso dopo anni) DI MOLTEPLICI CARDIOPATIE.**

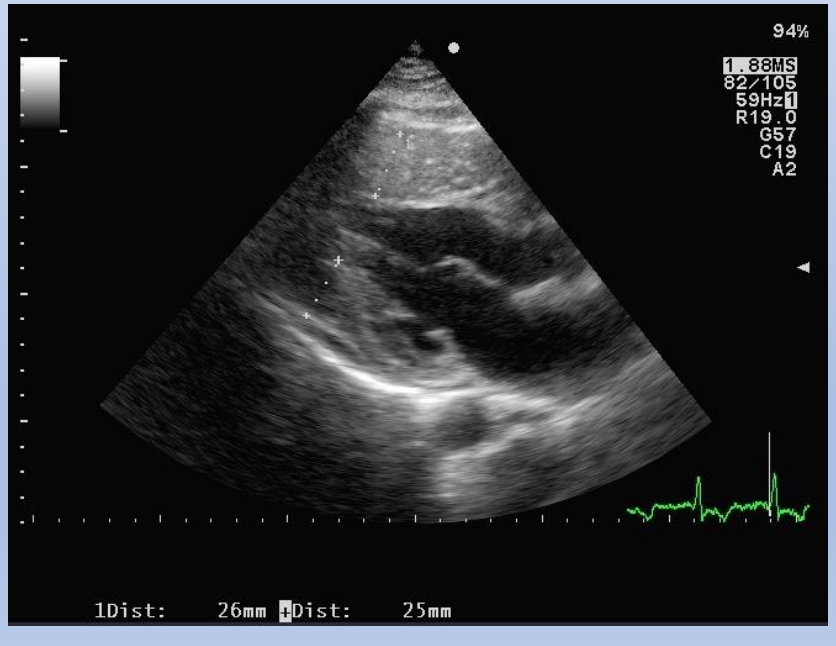


Pz di 49 aa, cardiopatia ischemica con severa dilatazione e severa riduzione della funzione del ventricolo sinistro FE 25%

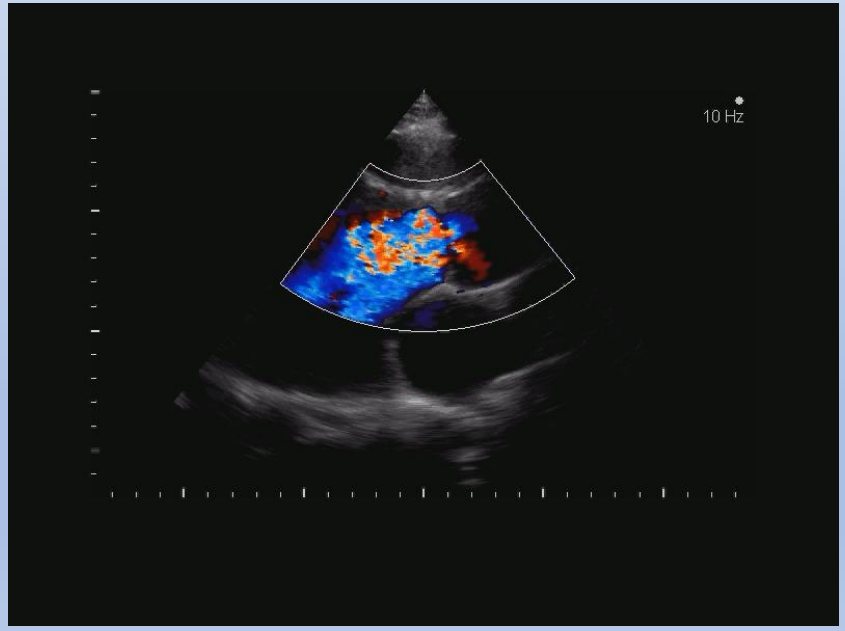




Pz di 21 aa, difetto interatriale e severa dilatazione di atrio e ventricolo destro

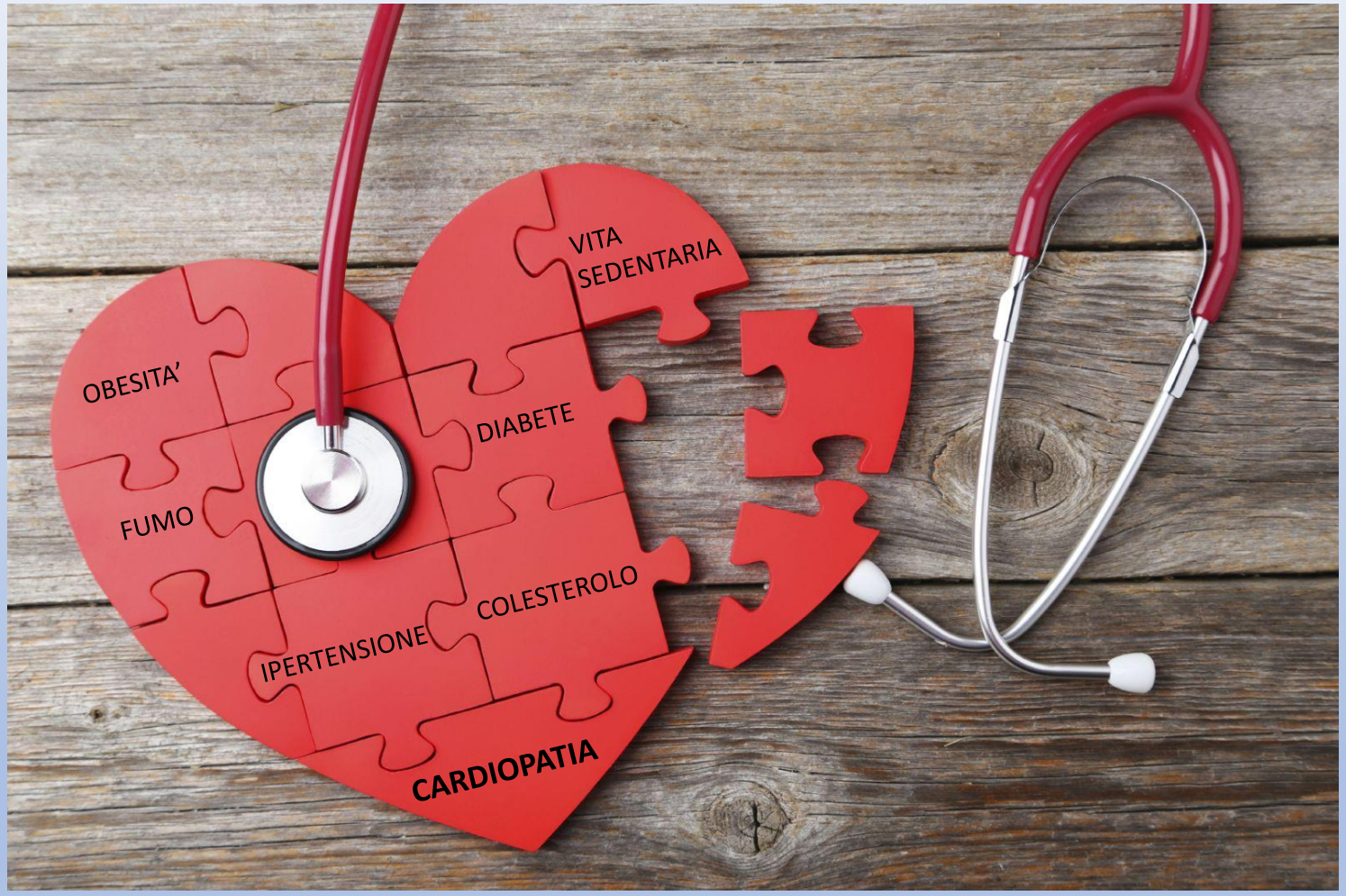


Pz di 32 aa, cardiomiopatia ipertrofica con severa ostruzione medioventricolare



Pz di 24 aa, insufficienza valvolare aortica massiva in valvulopatia reumatica mitro-aortica

UN LAVORO DI SQUADRA



GRAZIE PER L'ATTENZIONE